FOR OHF USE

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.

IDPH Facility ID Number: 0008524

Facility Name: Fairview Haven

Address: 605-609 North Fourth Street (Number) Fairbury (City) 61739 (Zip Code)

County: Livingston

Telephone Number: (815) 692-2572 **Fax #** (815) 692-4257

IDPA ID Number: 37-0814781001

Date of Initial License for Current Owners: 1962

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c) 3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Rick Plattner **Telephone Number:** (815) 692-2572

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2001 to 6/30/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ **(Date)**
(Type or Print Name) Rick Plattner
(Title) Administrator

Paid Preparer

(Signed) October 21, 2002 **(Date)**
(Print Name and Title) Robert Rein, Practitioner
(Firm Name & Address) Robert Rein, CPA, P.O. Box 201, Morton, Illinois 61550-0201
(Telephone) (309) 266-8178 **Fax #** ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	63	Skilled (SNF)	63	22,995	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	22,995	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		576	338	914	8
9	SNF/PED					9
10	ICF	7,888	13,583		21,471	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,888	14,159	338	22,385	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.35%

D. How many bed-hold days during this year were paid by Public Aid? 59 **(Do not include bed-hold days in Section B.)**

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Apartment & Condominium Rental for Elderly

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/28/62

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] **Date** 10/28/62 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 338

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/02 **Fiscal Year:** 06/30/02

*** All facilities other than governmental must report on the accrual basis.**

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	214,969	11,412	7,342	233,723		233,723	(77,525)	156,198			1
2	Food Purchase		178,743		178,743		178,743	(10,315)	168,428			2
3	Housekeeping	82,283	15,471		97,754		97,754		97,754			3
4	Laundry	57,343	10,827		68,170		68,170	(5,038)	63,132			4
5	Heat and Other Utilities			88,550	88,550		88,550	(29,347)	59,203			5
6	Maintenance	121,366	65,217	4,487	191,070		191,070	(7,337)	183,733			6
7	Other (specify):*											7
8	**TOTAL General Services**	475,961	281,670	100,379	858,010		858,010	(129,562)	728,448			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	1,016,248	36,466	138,555	1,191,269		1,191,269		1,191,269			10
10a	Therapy	68,612		7,024	75,636		75,636		75,636			10a
11	Activities	43,478	5,825	6,553	55,856		55,856		55,856			11
12	Social Services	33,977		1,117	35,094		35,094		35,094			12
13	Nurse Aide Training			1,415	1,415		1,415		1,415			13
14	Program Transportation			2,434	2,434		2,434		2,434			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,162,315	42,291	161,098	1,365,704		1,365,704		1,365,704			16
	C. General Administration											
17	Administrative	84,421			84,421		84,421		84,421			17
18	Directors Fees											18
19	Professional Services			42,041	42,041	(1,518)	40,523		40,523			19
20	Dues, Fees, Subscriptions & Promotions			13,188	13,188		13,188	(2,766)	10,422			20
21	Clerical & General Office Expenses	54,152	5,049	23,573	82,774	1,595	84,369	(2,055)	82,314			21
22	Employee Benefits & Payroll Taxes			322,523	322,523	55,797	378,320		378,320			22
23	Inservice Training & Education			580	580		580		580			23
24	Travel and Seminar			5,538	5,538	(77)	5,461	(81)	5,380			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			99,836	99,836	(55,797)	44,039		44,039			26
27	Other (specify):*											27
28	**TOTAL General Administration**	138,573	5,049	507,279	650,901		650,901	(4,902)	645,999			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,776,849	329,010	768,756	2,874,615		2,874,615	(134,464)	2,740,151			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fairview Haven, Inc. 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	**Salary/Wage 1**	**Supplies 2**	**Other 3**	**Total 4**	**5**	**6**	**7**	**8**	**9**	**10**	
30	Depreciation			129,181	129,181		129,181	(42,690)	86,491			**30**
31	Amortization of Pre-Op. & Org.											**31**
32	Interest			61,508	61,508		61,508	(45,807)	15,701			**32**
33	Real Estate Taxes			536	536		536	(536)				**33**
34	Rent-Facility & Grounds											**34**
35	Rent-Equipment & Vehicles											**35**
36	Other (specify):*											**36**
37	**TOTAL Ownership**			191,225	191,225		191,225	(89,033)	102,192			**37**
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											**38**
39	Ancillary Service Centers		21,662		21,662		21,662		21,662			**39**
40	Barber and Beauty Shops			12,066	12,066		12,066		12,066			**40**
41	Coffee and Gift Shops			3,690	3,690		3,690		3,690			**41**
42	Provider Participation Fee			34,461	34,461		34,461	32	34,493			**42**
43	Other (specify):*			2,426	2,426		2,426	(2,426)				**43**
44	**TOTAL Special Cost Centers**		21,662	52,643	74,305		74,305	(2,394)	71,911			**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,776,849	350,672	1,012,624	3,140,145		3,140,145	(225,891)	2,914,254			**45**

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** ######

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,221)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,707	30.3		9
10	Interest and Other Investment Income	(1,651)	32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,426)	43.3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(114)	20.3		28
29	Other-Attach Schedule	(223,186)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (225,891)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (225,891)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
This work paper section is not applicable.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This work paper section is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* **If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

** **This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This work paper section is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	A.C. Church Hail Assistance	X		Building Addition			$ 338,534	$ 287,040		4.50%	$ 17,352	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$ 338,534	$ 287,040			$ 17,352	9
	B. Non-Facility Related*											
10	A.C. Church Hail Assistance	X		Building Addition			861,466	730,430		4.50%	44,156	10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$ 861,466	$ 730,430			$ 44,156	14
15	**TOTALS (line 9+line14)**						$ 1,200,000	$ 1,017,470			$ 61,508	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Haven, Inc. COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0008524

CONTACT PERSON REGARDING THIS REPORT Rick Plattner

TELEPHONE (815) 692-2572 FAX #: (815) 692-4257

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

X. BUILDING AND GENERAL INFORMATION:

A. **Square Feet:** 22,213 **B. General Construction Type:** **Exterior** Brick **Frame** Block **Number of Stories** One

C. **Does the Operating Entity?** [X] **(a) Own the Facility** [ ] **(b) Rent from a Related Organization.** [ ] **(c) Rent from Completely Unrelated Organization.**

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. **Does the Operating Entity?** [X] **(a) Own the Equipment** [ ] **(b) Rent equipment from a Related Organization.** [ ] **(c) Rent equipment from Completely Unrelated Organization.**

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. **List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).**

F. **Does this cost report reflect any organization or pre-operating costs which are being amortized?** [ ] **YES** [X] **NO**
If so, please complete the following:

1. Total Amount Incurred: **2. Number of Years Over Which it is Being Amortized:**

3. Current Period Amortization: **4. Dates Incurred:**

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	90,000	1962	$ 6,422	1
2					2
3	TOTALS	90,000		$ 6,422	3

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	57		1962	1962	$ 145,220	$ 2,904	50	$ 2,904	$	$ 115,474	4
5	8		1999	1999	354,656		39	9,094	9,094	29,699	5
6											6
7											7
8											8
	Improvement Type**										
9	Additions 65-66			1965	258	5	50	5		189	9
10	Additions 66-67			1966	2,116	42	50	42		1,520	10
11	Additions 67-68			1967	13,436	269	50	269		9,409	11
12	Additions 69-70			1969	1,893	38	50	38		1,251	12
13	Additions 71-72			1971	26,066	521	50	521		16,158	13
14	Additions 72-73			1972	6,314	126	50	126		3,786	14
15	Additions 77-78			1978	4,507	90	50	90		2,207	15
16	Sprinkler System			1979	42,306	846	50	846		19,601	16
17	Generator Room			1979	8,460	169	50	169		3,918	17
18	Additions 78-79			1979	1,578	32	50	32		745	18
19	Driveway Asphalt			1978	1,475		10			1,475	19
20	Generator			1979	19,921		25	797	797	18,195	20
21	Smoke Detector			1980	6,529	261	25	261		5,788	21
22	Lights			1980	4,260	142	30	142		3,135	22
23	Additions 79-80			1979	3,516	70	50	70		1,615	23
24	Smoke Detector			1980	1,575		15			1,575	24
25	Additions 80-81			1981	16,207	324	50	324		6,968	25
26	Porch Enclosure			1981	9,453	189	50	189		3,938	26
27	Dining Room Lighting			1981	2,838	95	30	95		1,974	27
28	Lobby Lighting			1981	763	25	30	25		520	28
29	Linen Exhaust Fan			1982	376		10			376	29
30	Sprinkler System			1982	1,977	40	50	40		811	30
31	Room D2 Addition			1982	432	9	50	9		179	31
32	Room B14 Addition			1982	2,380	48	50	48		963	32
33	Exhaust Fan			1982	322		10			322	33
34	New Roof			1982	3,582		10			3,582	34
35	New Air Conditioner			1982	2,590		10			2,590	35
36	Remodel Kitchen & Dining Room			1983	8,205	164	50	164		3,172	36

***Total beds on this schedule must agree with page 2.**

****Improvement type must be detailed in order for the cost report to be considered complete.**

See Page 12A, Line 70 for total

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	New Sign	1983	$ 994	$	10	$	$	$ 994	37
38	Landscape	1983	1,455	49	30	49		926	38
39	Attic Fan	1983	1,381		10			1,381	39
40	Kitchen Cabinets & Fixtures	1983	619	31	20	31		575	40
41	Social Service Office	1984	227	5	50	5		87	41
42	Outside Light Fixture	1984	437		10			437	42
43	Blacktop Drive & Trees	1966	2,750		10			2,750	43
44	Laundry Room	1978	14,944	299	50	299		7,222	44
45	Trees	1984	920		10			920	45
46	Concrete Drive	1985	4,199		10			4,199	46
47	Remodeling Activity Rm & D-Wing	1986	167,304	8,365	20	8,365		136,631	47
48	Remodeling C-Wing Bath, Restroom Pilot Lights, D-Wing	1987	8,585	287	30	286	(1)	4,589	48
49	Courtyard--Original Set-up	1987	19,000	633	30	633		9,550	49
50	Remodel Linen Rm, Exit Lights, Utility, Wardrobe Shelves, Nursing Station	1988	21,731	764	17	1,281	517	18,374	50
51	Courtyard	1988	1,827	61	30	61		869	51
52	Patio Roof	1989	2,576	129	20	129		1,805	52
53	Attic Ceiling	1990	452		10			452	53
54	New Roof	1991	21,664	867	25	867		9,536	54
55	Plumbing-New Faucets-Resident Rooms	1992	6,148	410	10	409	(1)	6,148	55
56	Carport-Entryway Cover	1992	15,403	1,027	15	1,027		10,869	56
57	Kitchen Remodeling	1992	173,371	7,274	25	6,935	(339)	65,928	57
58	Office Remodel	1994	20,943	838	25	838		6,913	58
59	Kitchen Remodeling & Cabinets	1993	14,811	816	10	1,481	665	14,127	59
60	Kitchen Door, Trees, Carpet	1994	2,855	190	15	190		1,606	60
61	Sewer Extension	1995	2,697	180	15	180		1,320	61
62	Room B-1 & Drug Room Remodel	1995	833	33	25	33		242	62
63	Replace Main Sprinkler System	1995	2,550	170	15	170		1,223	63
64	Repair Dining Room Ice Machine Wall	1996	948	38	25	38		239	64
65	Front Parking Lot & Sidewalk	1995	20,675	1,378	15	1,378		9,182	65
66	Door Alarm System	1995	6,226	741	7	746	5	6,226	66
67	Ceiling Mount Smoke Detectors-Resident Rms	1995	183	26	7	26		176	67
68	Nurse Call System	1995	27,948	3,993	7	3,993		24,942	68
69	Ceiling Mount Smoke Detectors-Resident Rms	1996	3,211	459	7	459		2,790	69
70	**TOTAL (lines 4 thru 69)**		$ 1,263,078	$ 35,472		$ 46,209	$ 10,737	$ 614,363	70

****Improvement type must be detailed in order for the cost report to be considered complete.**

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,263,078	$ 35,472		$ 46,209	$ 10,737	$ 614,363	1
2	Draperies	1997	1,086	155	7	155		852	2
3	Phone System	1997	12,981	1,298	10	1,298		6,703	3
4	Fire Alarm System	1997	324	46	7	46		245	4
5	Door Alarm System	1997	439	63	7	63		336	5
6	Ceiling Mount Smoke Detectors-Resident Rms	1997	191	27	7	27		148	6
7	Door Alarm System	1996	724	103	7	103		575	7
8	Courtyard Landscaping	1996	649	43	15	43		254	8
9	Window Coverings	1998	1,798	257	7	257		1,133	9
10	Intercom System	1998	15,310	2,187	7	2,187		9,287	10
11	Nurse Call System	1997	2,148	307	7	307		1,431	11
12	Fire Alarm System	1998	744	106	7	106		450	12
13	Telephone System	1997	461	66	7	66		313	13
14	Smoke Detectors	1999	108	15	7	15		53	14
15	Bathroom Sprinkler System	2000	1,873	125	15	125		260	15
16	Sink	2000	746	107	7	107		267	16
17	Water Heater	1999	6,669	667	10	667		1,944	17
18	Water Heater	2001	3,647	365	10	365		475	18
19	B Wing Air Conditioner	2000	1,623	232	7	232		424	19
20	Dry Pendants - Shower room	2000	2,762	276	10	276		517	20
21	Nurses Station Carpet	2000	1,151	115	10	115		206	21
22	Large Capacity Water Heater	2001	5,290	529	10	529		616	22
23	Telephone System	2002	853	41	7	38	(3)	38	23
24	Air Conditioning Unit	2002	1,730	29	10	22	(7)	22	24
25	Nurse Call System	2002	64,740	2,698	10	2,678	(20)	2,678	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	**TOTAL (lines 1 thru 33)**		$ 1,391,125	$ 45,329		$ 56,036	$ 10,707	$ 643,590	34

****Improvement type must be detailed in order for the cost report to be considered complete.**

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 150,770	$ 17,914	$ 17,914	$	various	$ 128,129	71
72	Current Year Purchases	45,000	1,714	1,714		various	1,714	72
73	Fully Depreciated Assets	346,607				various	346,607	73
74								74
75	TOTALS	$ 542,377	$ 19,628	$ 19,628	$		$ 476,450	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	Ford Van 83	01/01/84	$ 17,000	$	$	$	4	$ 17,000	76
77	Patient Transport	Paint Ford Van	01/01/90	1,557				3	1,557	77
78	Patient Transport	Ford Clubvan Triton V-10 '98	05/01/98	46,290	9,258	9,258		5	38,554	78
79	Patient Transport	Dodge Van 96	08/07/01	11,983	1,569	1,569		7	1,569	79
80	TOTALS			$ 76,830	$ 10,827	$ 10,827	$		$ 58,680	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,016,754	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 75,784	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 86,491	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,707	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,178,720	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	Non-Care Assets	2,080,558	53,397	524,332	87
88					88
89					89
90					90
91	TOTALS	$ 2,080,558	$ 53,397	$ 524,332	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 1,481,613	92
93			93
94			94
95		$ 1,481,613	95

* **Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.**

** **This must agree with Schedule V line 30, column 8.**

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [x]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [x]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 1,415	$	$ 1,415
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 1,415	$	$ 1,415
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,415			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Fairview Haven, Inc. **STATE OF ILLINOIS** # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$	71	$ 4,156	$	71	$ 4,156	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		16	931		16	931	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				4,657		4,657	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Medical Supplies	39.2					17,005		17,005	13
14	TOTAL			$	87	$ 5,087	$ 21,662	87	$ 26,749	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 157,251	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	212,608		3
4	Supply Inventory (priced at FIFO)	18,925		4
5	Short-Term Investments			5
6	Prepaid Insurance	23,429		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 412,213	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	34,814		13
14	Buildings, at Historical Cost	1,592,098		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	667,086		16
17	Accumulated Depreciation (book methods)	(1,631,033)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	1,481,613		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,144,578	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,556,791	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (49,747)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(89,856)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(815)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (140,418)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	(1,017,470)		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (1,017,470)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (1,157,888)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,398,903)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (2,556,791)	$	48

***(See instructions.)**

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** ###### **Ending:** 6/30/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	**$** 1,203,528	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,203,528	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	195,376	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(1)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 195,375	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,398,903	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ (2,599,781)	1
2	Discounts and Allowances for all Levels	32,904	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ (2,566,877)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(46,079)	6
7	Oxygen	(6,800)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ (52,879)	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	(6,826)	12
13	Barber and Beauty Care	(10,084)	13
14	Non-Patient Meals	(9,221)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(17,520)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(1,507)	19
20	Radiology and X-Ray		20
21	Other Medical Services	(32,140)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (77,298)	23
	D. Non-Operating Revenue		
24	Contributions	(181,186)	24
25	Interest and Other Investment Income***	(5,853)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (187,039)	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Residential Revenue	(444,868)	28
28a	Other Income	(6,560)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (451,428)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ (3,335,521)	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	858,010	31
32	Health Care	1,365,704	32
33	General Administration	650,901	33
	B. Capital Expense		
34	Ownership	191,225	34
	C. Ancillary Expense		
35	Special Cost Centers	39,844	35
36	Provider Participation Fee	34,461	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,140,145	40
41	**Income before Income Taxes (line 30 minus line 40)****	(195,376)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (195,376)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,763	1,986	$ 46,959	$ 23.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,267	12,035	225,515	18.74	3
4	Licensed Practical Nurses	13,493	14,851	260,434	17.54	4
5	Nurse Aides & Orderlies	35,622	38,347	459,365	11.98	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,780	5,246	68,612	13.08	8
9	Activity Director	1,901	2,083	20,294	9.74	9
10	Activity Assistants	1,800	1,981	23,184	11.70	10
11	Social Service Workers	3,087	3,337	33,977	10.18	11
12	Dietician					12
13	Food Service Supervisor	2,188	2,212	33,073	14.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,792	17,817	181,896	10.21	15
16	Dishwashers					16
17	Maintenance Workers	6,296	6,755	121,366	17.97	17
18	Housekeepers	7,254	7,893	82,283	10.42	18
19	Laundry	4,993	5,462	57,343	10.50	19
20	Administrator	1,669	1,831	84,421	46.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,333	2,472	54,152	21.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerk	2,244	2,459	23,975	9.75	33
34	TOTAL (lines 1 - 33)	117,482	126,767	$ 1,776,849 *	$ 14.02	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	139	$ 7,342	1.3	35
36	Medical Director	40	4,000	9.3	36
37	Medical Records Consultant	22	970	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	28	1,960	10.3	39
40	Physical Therapy Consultant	35	1,937	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	2,600	11.3	44
45	Social Service Consultant	22	1,117	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	331	$ 19,926		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 315	10.3	50
51	Licensed Practical Nurses			10.3	51
52	Nurse Aides	5,896	132,073	10.3/10a.3	52
53	TOTAL (lines 50 - 52)	5,904	$ 132,388		53

Facility Name & ID Number Fairview Haven, Inc. **STATE OF ILLINOIS** # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rick Plattner	Administrator	-0-	$ 84,421
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,421

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Paul Kelson, CPA	Accounting	$ 962
Heinold Banwart	Accounting	5,000
Robert Rein, CPA	Consulting	8,154
Gardner & White	Accounting	1,421
Duane, Morris etal	Legal	24,986
Reclass of Non-Professional Expenses		1,518
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		**$** 42,041

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,797
Unemployment Compensation Insurance	148
FICA Taxes	129,261
Employee Health Insurance	123,020
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Pension Plan	33,684
Employee Life/Disability	20,644
Employee Flexible Spending	2,223
Employee Uniforms	500
Employee Appreciation	13,042
TOTAL (agree to Schedule V, line 22, col.8)	$ 378,320

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		**$**

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 35
Advertising: Employee Recruitment	6,695
Health Care Worker Background Check	528
(Indicate # of checks performed 44 **)**	
Life Services Network of IL	3,768
Progressive Business Publications	230
Dues & Licenses	1,028
Subscriptions	414
Newspapers	490
Less: Public Relations Expense	( )
Non-allowable advertising	(2,652)
Yellow page advertising	(114)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,422

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Staff	(81)
In-State Travel	
Staff	1,270
Administration	539
Seminar Expense	
Staff	3,053
Administration	599
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,380

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** #######

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Fairview Haven, Inc. # 0008524 **Report Period Beginning:** 7/1/2001 **Ending:** #######

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of IL 3,768

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 20,682 Line 10.2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. No

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 34,493
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? Yes Indicate the amount. $ 9,221

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.